

Overwork and health issues self-referred by caregivers of elderly

Fonsêca, Ianna Cibebe Delgado de Araújo; Nóbrega, Maria Miriam Lima da; Monteiro, Edilene Araújo; Bittencourt, Greicy Kelly Gouveia Dias; Silva, Antonia Oliveira

Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:

Fonsêca, I. C. D. d. A., Nóbrega, M. M. L. d., Monteiro, E. A., Bittencourt, G. K. G. D., & Silva, A. O. (2015). Overwork and health issues self-referred by caregivers of elderly. *Revista de Pesquisa: Cuidado é Fundamental Online*, 7(Supl.), 222-232. <https://doi.org/10.9789/2175-5361.2015.v7i5.222-232>

Nutzungsbedingungen:

Dieser Text wird unter einer CC BY-NC Lizenz (Namensnennung-Nicht-kommerziell) zur Verfügung gestellt. Nähere Auskünfte zu den CC-Lizenzen finden Sie hier:
<https://creativecommons.org/licenses/by-nc/4.0/deed.de>

Terms of use:

This document is made available under a CC BY-NC Licence (Attribution-NonCommercial). For more information see:
<https://creativecommons.org/licenses/by-nc/4.0>

RESEARCH

Sobrecarga e problemas de saúde autorreferidos por cuidadores de idosos

Overwork and health issues self-referred by caregivers of elderly

Sobrecarga y problemas de salud auto-reportados por los cuidadores de idosos

Ilanna Cibebe Delgado de Araújo Fonsêca¹, Maria Miriam Lima da Nóbrega², Edilene Araújo Monteiro³, Greice Kelly Gouveia Dias Bittencourt⁴, Antonia Oliveira Silva⁵

ABSTRACT

Objective: verifying the caregiver burden of elderly and identify health problems self-reported by caregivers of elderly. **Method:** this is a quantitative study, observational and cross-cutting nature, developed in the city of João Pessoa. The target population was composed of 251 caregivers of the elderly, attended in primary care. After examination of the consistency of the data collected sample consisted of 219 Data collection was conducted through interviews with caregivers in primary care services and PIER Caisi of the municipality, from April to June 2011, using the overhead of scale Burden Interview and the scale of self-reported health problems (Self reporting questionnaire). Data were transported to the SPSS program, where the statistical analysis of the data was performed. **Results:** it could be noted that 50,7% of the caregivers had overhead, among them, 81,8% moderate overload mild, 15,4% moderate to severe and 2,8%, intense. As for the health problems of caregivers, only one was self-reported with high frequency. **Conclusion:** we conclude that caregivers require implementation of care actions, in order to receive their distress and to minimize their burdens, contributing in this regard for quality of life improvements thereof. **Descriptors:** Nursing, Elderly Caregiver, Workload, Primary Health Care.

RESUMO

Objetivo: verificar a sobrecarga do cuidador de idosos e identificar os problemas de saúde autorreferidos pelos cuidadores de idosos. **Método:** trata-se de estudo de natureza quantitativa, observacional e transversal, desenvolvida no município de João Pessoa. A população-alvo foi composta por 251 cuidadores de idosos, atendidos na atenção básica. Após análise da consistência dos dados coletados a amostra foi constituída por 219. A coleta de dados foi realizada mediante entrevista aos cuidadores nos serviços de atenção básica CAIS e CAISI do referido município, no período de abril a junho de 2011, utilizando a escala de sobrecarga *Burden Interview* e a escala de problemas de saúde autorreferidos (*Self reporting questionnaire*). Os dados foram transportados para o Programa SPSS, onde foi realizada a análise estatística dos mesmos. **Resultados:** pôde-se evidenciar que 50,7% dos cuidadores apresentaram sobrecarga, dentre eles, 81,8%, sobrecarga moderada a leve, 15,4%, moderada a severa e 2,8%, intensa. Quanto aos problemas de saúde dos cuidadores, apenas um foi autorreferidos com alta frequência. **Conclusão:** Conclui-se que os cuidadores requerem implementação de ações cuidativas, de modo a acolher suas angústias e a minimiza as suas sobrecargas, contribuindo, nesse sentido, para melhorias da qualidade de vida dos mesmos. **Descritores:** Enfermagem, Idoso, Cuidador, Sobrecarga, Atenção básica.

RESUMEN

Objetivo: verificar la carga de los cuidadores de personas mayores e identificar los problemas de salud auto-reportados por los cuidadores de ancianos en la ciudad de João Pessoa - PB. **Método:** se trata de un estudio cuantitativo, observacional y carácter transversal, desarrollado en la ciudad de João Pessoa. La población objetivo se compone de 251 cuidadores de ancianos, atendidos en la atención primaria. Tras examinar la consistencia de los datos muestra recogida consistió en 219 Recopilación de datos se realizó a través de entrevistas con los cuidadores en los servicios de atención primaria y el muelle Caisi del municipio, de abril a junio de 2011, mediante la sobrecarga de escala Entrevista de Carga y la escala de los problemas de salud auto-reporte (auto-cuestionario de informes). Los datos fueron transportados al programa SPSS, donde se realizó el análisis estadístico de los datos. **Resultados:** se podría señalar que el 50,7% de los cuidadores tenía encima de la cabeza, entre ellos, el 81,8% de sobrecarga moderada leve, el 15,4% de moderada a grave y el 2,8%, intenso. En cuanto a los problemas de salud de los cuidadores, sólo uno era de auto-reporte con alta frecuencia. **Conclusión:** concluimos que los cuidadores requieren la implementación de acciones de atención, a fin de recibir sus tribulaciones, y minimizar sus cargas, lo que contribuye en este sentido por la calidad de las mejoras de vida de los mismos. **Descriptor:** Ancianos, Cuidador de ancianos, Sobrecarga de Trabajo, Atención Primaria de Salud.

¹Phonaudiologist. Student of the Specialization Course Attention to Health and Aging MS / UFPB. ² Nurse. Doctor. Professor of the Graduate Nursing UFPB Program. CNPq Researcher. E-mail: miriam@ccs.ufpb.br. ³Enfermeira. Doctor. Professor UFPB. ⁴PNPD Scholarship Program Graduate Nursing UFPB. João Pessoa / PB. E-mail: greicykel@gmail.com. ⁵Nurse. Doctor. Professor of the Graduate Nursing UFPB Program. CNPq Researcher. E-mail: alfaleda2@gmail.com.

INTRODUCTION

During the aging process, there are no hard limits, with chronological determinants for each stage of aging. Senescence gives way to senility, that is, the emergence of diseases in a very subtle way. Aging is a natural process that features a man's life stage and occurs by physical, psychological and social changes that affect a particular way each individual with prolonged survival. It is a stage where, pondering the very existence, the old guy concludes that achieved many goals, but also suffered many losses, among which stands out the involvement of losses in their functional capacity due mainly to the high incidence of diseases chronic in the elderly¹ population. Nevertheless, other authors², point out that aging is a process that causes changes and wear in various functional systems that occur in a progressive and irreversible and that, coupled with the development of chronic diseases, cause in people elderly, generally, loss of autonomy and ability to perform daily activities.

For this reason, become need constant care (partial or complete) of care and support systems.

In this scenario, there is the figure of the caregiver, defined by the National Policy for the Elderly Health (PNSI) as a person, member or not the family, who, with or without remuneration, takes care of sick or elderly dependent, in carrying out its activities daily life, such as food, personal hygiene, routine medications, monitoring health services or other services that require in daily life, excluding techniques or procedures identified with legally established professions, particularly in nursing³.

In the gerontological literature there is consensus that care can be implemented both by the family and by health professionals and institutions, the use of formal and informal terms devoting themselves to designate the type of support offered to the dependent elderly. In this context, it is called the caregiver hired professional, properly trained and enabled, which provides assistance to the elderly and/or family. Is called informal caregiver, in turn, family members, friends, neighbors or voluntary, unpaid, without specific training, which takes care of the elderly in the family context⁴.

At the time of an event that compromises the dependency or the functional capacity of the elderly, most often, is the family, in the figure of the family caregiver, which primarily takes responsibility for the care to dependent elderly. It is noteworthy, however, that the person who takes care of the dependent elderly not always be chosen caregiver. The need for a family member dispenses daily care to dependent elderly appears more of a circumstantial imposition of a personal choice.

Once you choose to provide care to the dependent elderly, the family caregiver is challenged to deal with new roles, without, in most cases, previous and basic knowledge as well as technical and social support resources to carry out their activities. The family has become almost always the only available source of funds for the care of dependent elderly, which contributes to the appearance of negative impact or burden among family caregivers.

This impact or overload can be defined as physical problems, psychological or emotional, social and financial arising from the care process.

In addition, it is noteworthy that dispense care to someone who is ill or dependent, inevitably, involve mental, physical and considerable psychological stress, as well as the financial burden that eventually care entails. To be added to that the fact that the tasks are assigned to the family caregiver, often without the proper guidance and support of health institutions, it is clear how serious consequence a significant impact on the quality of care provided, as well as on their health caregiver.

As part of the research, the theme on the phenomenon of overload of family caregivers as well as to the deleterious effects of this phenomenon on the caregiver's own health has been identified as being relatively new, demonstrating a more significant number of publications on the subject, only in recent years. In the context of the state of Paraíba, specifically the city of João Pessoa, there are few investigations into this phenomenon.

In this scenario, if sought, in this study, answers to the following guiding questions: Family caregivers of elderly patients in low health units and average complexity of the city of João Pessoa-PB feel overwhelmed by the work they do? What are the health problems self-reported by family caregivers of elderly patients in low health units and average complexity of the city of João Pessoa-PB? In order to respond to questions now exposed, the following objectives were defined: to estimate the burden of family caregivers of elderly patients in low health units and average complexity of the city of João Pessoa, PB; and identify health problems self-reported by family caregivers of elderly patients in low health units and average complexity of the city of João Pessoa-PB.

METHOD

This is a quantitative research, observational and cross-sectional developed in the city of João Pessoa, PB. The target population consisted of caregivers of elderly people living at home, attended in Family Health Units in the Comprehensive Care Centers Health (CAIS) and the Comprehensive Care Center for Elderly Care (Caisi) of said municipality, making a total of 251 caregivers. After analysis of the consistency of the data collected the study sample was composed of 219 caregivers.

Previously sent to the Research Ethics Committee of the University Hospital Lauro Wanderley/UFPB, the research project was submitted to and approved in accordance with the opinion of that body (Protocol 261/09). It is worth noting that the development of the research was guided by Resolution No. 196 of October 10th, 1996, the National Health Council of the Ministry of Health⁵, with regard to regulation of research on human subjects and assures study participants information about their goals and their development, anonymity, respect and confidentiality with respect to information provided and freedom to give up participating in the study in any of its phases. For this, we used the Consent and Informed.

Data collection was conducted through interviews with caregivers, effective in health institutions referred to, in the period from April to June 2011, with an average duration of 50 minutes. The team of interviewers consisted of 25 students of the Specialization Course in Health and Aging at the Federal University of Paraiba - UFPB, which were properly trained to perform such a procedure. For the apprehension of the data, the following instruments were used: semi-structured questionnaire with information regarding sociodemographic conditions of the caregivers; the scale of self-reported health problems (Self reporting questionnaire), which covers twenty items in a dichotomous scale of yes and not; and the Burden Interview scale, developed by Steve Zarit and validated in the Brazilian context⁶, which aims to assess the existence of objective burden and subjective caregiver.

In Burden Interview scale, each item is scored investigated and meets the following scores: never (0), rarely (1), sometimes (2) often (3) where (4), and in the last question scores are: not at all (0), a little (1), moderate (2), very (3) extremely (4). The total score ranges from 0 to 88, and the biggest one corresponds to a higher perception of overload. To classify the level of workload evidenced by caregivers, it was used in this study the cutoff established in the international context⁷, and in Brazilian scene⁸⁻⁹. Thus, obeyed to the following classification: scores between 61 and 88 indicate intense overload; between 41 and 60, overload moderate to severe; between 21 and 40, moderate to mild overload; and lower scores 21, no overload. We also used the scale of self-reported health problems (Self reporting questionnaire), which includes twenty items in a dichotomous scale of yes and no.

The data were entered into a database in Excel, after the second entry and data validation, transported to the SPSS program, which conducted the statistical analysis (averaging, standard deviation, absolute frequency and relative frequency).

RESULTS

The results of the descriptive analysis of each item of Burden Interview Scale are shown in Table 1. The items that showed higher frequency and were marked as "always" were happening: "He feels that elderly depends on the Mr./Mrs." with 68 (31,1%) and "Do you feel that the elderly waiting to look after him as if it were the only person (s) he can depend" with 47 (21,5%). The items that obtained in response the "never", prevailed the item on the question "Do you feel embarrassed by the old behavior," with 182 (83,1%). Of items marked "often" showed the highest frequency was "Do you feel that the elderly depends on the Mr./ Mrs." with 44 (20,1%). Note the fact that the 22 items of the scale, 12 items were marked with frequency equal to or above 50% as "never" presented, and the options of "rarely" and "sometimes" were not marked in the 22 items scale with frequency equal to or above 50%.

Table 1 - Workload distribution of elderly caregivers in Basic Health Units in CAIS and CAISI.
João Pessoa, 2011 (n = 219).

	Never		Rarely		Sometimes		Frequently		Always	
	N	%	N	%	N	%	N	%	N	%
Feels that S* asks for more than he needs	97	44,3	45	20,5	45	20,5	16	7,3	16	7,3
You don't have enough time for you	87	39,7	45	20,5	55	25,1	14	6,4	18	8,2
Do you feel stressed out between care and other responsibilities	81	37,0	43	19,6	70	32,0	12	5,5	13	5,9
Do you feel embarrassed by the behavior of S*	182	83,1	17	7,8	17	7,8	3	1,4	0,0	0,0
Do you feel angry when S* is around	173	79,0	23	10,5	20	9,1	1	0,5	2	0,9
Feels that negatively affects your relationships	175	79,9	25	11,4	15	6,8	3	1,4	1	0,5
Feel fear for the future of S*	59	26,9	25	11,4	70	32,0	28	12,8	37	16,9
Feels that S* it depends on the Mr/Ms	29	13,2	29	13,2	49	22,4	44	20,1	68	31,1
He feels tense when S* is around	172	78,5	22	10,0	18	8,2	5	2,3	2	0,9
Feel that your health has been affected by your involvement with S*	149	68,0	28	12,8	21	9,6	11	5,0	10	4,6
You don't have as much privacy as I'd like because of S*	142	64,8	24	11,0	35	16,0	7	3,2	11	5,0
He feels that his personal life has been undermined for taking care of S*	135	61,6	23	10,5	39	17,8	14	6,8	8	3,7
Do not feel free to have company at home	174	79,5	19	8,7	15	6,8	13	1,4	8	3,7
Feel that they are expected to take care of him, as if he were the only person whom he can depend on	67	30,6	32	14,6	54	24,7	19	8,7	47	21,5
Feel not having enough money	87	39,7	34	15,5	48	21,9	20	9,1	30	13,7
Feels unable to take care of S* much longer	130	59,4	24	11,0	44	20,1	8	3,7	13	5,9
Feels that he lost control of his life since the disease of S*	159	72,6	18	8,2	27	12,3	4	1,8	11	5,0
I would like to let someone else take care of S*	146	66,7	21	9,6	40	18,3	4	1,8	8	3,7
Feels doubt about what to do for S*	115	52,5	45	20,5	46	21,0	8	3,7	5	2,3
Feel you should do more for S*	57	26,0	41	18,7	76	34,7	20	9,1	25	11,4
Feel like you could take better care of S*	62	28,3	41	18,7	71	32,4	18	8,2	27	12,3
How do you feel overwhelmed by caring for S*	78	35,6	72	32,9	39	17,8	25	11,4	5	2,3

The data investigated by applying the Burden Interview overload scale enable the following findings: the average global burden of family caregivers in this study was 22,3 points, with a standard deviation of 13,5, with an average minimum found zero points and a maximum of 70 points; this overall average is part of the moderate overload rating to light. Showed a prevalence of 50,7% of the burden in caregivers investigated; of these, 81,8% had moderate overload mild, 15,4% moderate to severe overload and 2.8%, severe overload.

In Table 2 shows the distribution of the frequency of self-reported health problems by caregivers of elderly patients in primary health care units in the ACHR and Caisi. The data show a higher proportion of caregivers who reported having health problems. The item at that caregivers reported having as a health problem, a frequency equal to or greater than 50%, was referred to "Do you feel nervous, tense or worried?" It showed also a significant number of caregivers who reported having the following health problems: "bad sleep" 98 (44,7%) and "has felt sad lately" 93 (42,5).

Table 2 - Distribution of frequency of self-referred health problems by the caretaker of elderly in Basic Health Units in CAIS and CAISI. João Pessoa, 2011 (n = 219).

VARIABLES	NO		YES	
	N	%	N	%
Has frequent headaches	151	68,9	68	31,1
Lack of appetite	181	82,6	38	17,4
Sleeps bad	121	53,3	98	44,7
Get's afraid easily	153	69,9	66	30,1
Have hand tremors	192	87,7	27	12,3
Feels nervous, tense or worried	103	47,0	116	53,0
Bad digestion	160	73,1	59	26,9
Have difficulty thinking clearly	154	70,3	65	29,7
Has sense down lately	126	57,5	93	42,5
Have cried more than usual	166	75,8	52	23,7
Find it difficult to perform your daily activities with satisfaction	156	71,2	63	28,8
Difficulties in decision making	139	63,5	80	36,5
Has difficulty in service (your job is painful, it causes suffering)	171	78,1	48	21,9
Is unable to play a useful role in your life	199	90,9	20	9,1
Has lost interest in things	179	81,7	40	18,3
You feel a person worthless, no-good	211	96,3	8	3,7
Has had the idea of ending the life	211	96,3	8	3,7
Feels tired all the time	164	74,9	55	25,1
Have unpleasant sensations in the stomach	148	67,6	71	32,4
Get tired easily	153	69,9	66	30,1

DISCUSSION

The dependence accompanied by aging, a process that has been accented with increased longevity, becomes a new challenge for public health in Brazil, in order to ensure conditions for proper care for dependent elderly living in the community, given the conditions of which the family really has to take responsibility for that assistance. At the same time, a different view of care to these elderly, since even share of poor visibility on the deficit care support and the devaluation of their work taken as a natural issue to family members, especially women is necessary.

In the care of a dependent entity blend practical, financial, motivations and emotions, giving rise to conflicts and ambivalences, that is, the care is not always a linear situation experienced in the same way. At beginning of year paper, the requirements seem stronger, but over time, due to adaptive processes and the variety of processes occurring in family life that cares, the sense of overload may stabilize or decrease. In this sense, one should not think in care as an activity that necessarily brings negative effects and burden on caregivers¹⁰.

So while most studies addressing the negative aspects of being caregiver, care can also generate positive feelings, such as satisfaction. These feelings arise from the meanings attributed by the caregiver to various aspects of the situation, since the feeling of being fulfilling a moral duty or being returning to the care received in the past, to the recognition that others express about their performance¹¹.

However¹², point out that the feeling of satisfaction among caregivers is observed when the families are emotionally and economically structured to accommodate the dependent elderly. In contrast, deficiency of these features, in most cases, the appearance of supports for higher levels of tension and overload among caregivers.

From the calculation of workload score proposed by the Zarit scale, it was possible to verifying this study the prevalence and the average burden among caregivers of the elderly involved in the study were equivalent to 50,7% and 22,3%, respectively. These findings allow us to infer that the overall average score overload is part of the qualification of the "moderate overload the light." Among caregivers who presented workload (50,7%).

With regard to the questions included in the Zarit Overload Scale, it was observed, among respondents, higher prevalence of response "never" to the question related to "feel embarrassed about the old behavior", corroborating the results of other studies that addressed the phenomenon in question⁹⁻³. Note that close relationship, affection, attention and love between the family caregiver and dependent elderly people is an important influence in the care process, enabling often that care occurs without being permeated by negative feelings.

The proximity and the type of existing affective relationship between the caregiver and the care being before the disease or its dependence contribute to the process of integration and adaptation of caregiver to that role, so that the more positively has been experienced this relationship, the better the adaptation of caregivers and hence the lower the possibility of tensions and overhead between them¹¹.

There were also a higher proportion of caregivers who responded "always" to the questions relating to "feel that elderly depends on the caregiver" and "feel that the elderly expects the caregiver look after him/her, like the only person (s) he can depend." In this context, there is evidence of a high degree of dependence on the relationship between the dependent elderly and their caregivers and therefore the high level of responsibility that the caregiver has about maintaining the old life, through the care provided daily, which substantially contributes to the appearance of increasing levels of overload and between caregivers.

Associated with the involvement of overload, various research has highlighted the negative effects of the care process on the physical and mental health of the caregiver, reflected in high prevalence of psychiatric disease, use higher than normal psychotropic drugs, increased somatic diseases, social isolation, personal and family stress¹⁰.

As part of this study, health problems most frequently reported by caregivers were "feeling nervous, tense or worried", "sleep badly" and "sad feeling lately." This finding guard line with results of other studies^{14, 15, 16} showed that among the following feelings caregivers: grief, sorrow, worry, nervousness, stress, tension, depression, social isolation, among others; which may have a negative effect on the quality of life of the caregiver and hence on the quality of care provided.

Several factors are linked to determine the feelings that are triggered by assuming the role of caregiver, such as patient-related factors such as the degree of physical and emotional dependency, and especially the caregiver own characteristics and its ability to adapt and face adversity. Still interact in determining the sentiments expressed by caregivers how these people were prepared to deal with separations and personal losses, material or economic, social support, family and friends, and other community resources,

such as accessibility to rehabilitation programs. The complexity of these factors explains the variability found in feelings of caregivers in different contexts¹⁷.

A considerable number of respondents (44.3) never feel that the elderly asks for more help than you need. Unlike the study¹³, which showed a high percentage of 63,7% compared to current research. With regard to long enough for you, there is a decrease in the percentage of 39,7%; that is, of those, 37,0% feels stressed in care and other responsibilities, deducting a decline in the percentage of response in relation to rarely, sometimes, often and always.

Regarding the affection, the results¹³ shows the existence of percentages comparable with the results obtained in this study with regard to "never shame with the old behavior" with 84,9%, "do not feel irritability when around "with 79.0%, the same" do not feel that negatively affects your relationships "with 79,9% and the same premise, we have never for questioning" did not feel the desire to have visit at home "with 79,5%. The same applies to the item "fear for the future of the elderly and their dependence" which obtained a percentage of never (26,9%), rarely (11,4%), sometimes (32,0%), often (12,8%) and always (16,9%).

Contradicting the findings¹³, in relation to health, organic and psychological, the results of this study show that 78,5% never feel tense when the elderly is close by, 64,8% feel that their health was affected by his involvement with the elderly and 61,6% feel that personal life has been marred by caring for the elderly, nor feel that a careful person expected to take care of it as if it were the only person he/she may depend on presenting a score of 30,6%.

Caregivers respondents 39,7% said never feel the lack of money to meet their needs. According to the finding¹³ notes a reversal of values, when it was identified that 54,6% reported often feel a lack of money to take care of the elderly.

When asked about the care of disability with a careful person, 59,4 of the participants never feel unable to care for the aged for much longer and just as 66,7% never like to let someone else take care. Given the fact that caregivers feel they have lost control of your life since the illness of the person cared for 219 respondents, or 72,6% said never.

From the calculation of workload scores of elderly caregivers attended at Basic Health Units in CAIS and Caisi shown in Table 2, it was observed that 49,3% of caregivers have no workload, 41,5% are classified workload for "moderate to mild", and 9,2% present a workload "high" or "moderate to severe." Note that there is no agreement with findings in the data¹² Moreira (2009), when 86,4% of the participants showed caregiver burden.

Analyzing the findings⁹ in his study, there was a resemblance to our data, when he found a light to moderate workload with the percentage of 27,8% respondents. When we talk about high workload, in the previous question, one of the explanations in this perspective can be found in the research¹⁸, when there is an important percentage of caregivers (62,6%) by has other duties besides the care of the elderly, often doing double shifts and triple work.

According⁹, caregivers caring for elderly patients with multiple diagnoses, with no depression and dementia and or other behavioral problems, had lower average burden.

Another element that draws attention to the study results is that only a problem of the twenty listed in the instrument was self-reported with high frequency - "Do you feel nervous, tense or worried." This data reinforces the fact that the vast majority of caregivers

not present workload. There is a similar fact when we analyzed data from⁹, when 68,0% they feel nervous, tense or worried and 59.2 feels sad. Thus, the self-reported health problems are related to the level of caregiver burden associated with great dedication and love for the care.

The personal and emotional stress of the immediate caregiver is huge. These caregivers need to keep your physical and emotional integrity to plan ways of living together. Understand their own feelings and accept them as a normal process of psychological growth¹⁹.

CONCLUSION

The elderly caregiver is an element present in the Brazilian healthcare scenario usually linked to situations of family conflict and the lack of information necessary for the attention of performance in this sense it is worth noting that the act of care for the elderly must be cataloged in mutual respect between caregiver and the one cared for improvement in the health status of both the caregiver and the care to be. In this study we observed that 49.3% of the caregivers do not exhibit overload, 41,5% are classified overload "mild moderate," and 9,2% had an overload "high" or "moderate to severe."

Another element that draws attention to the study results is that only a problem of the twenty listed in the self-reported instrument - "Do you feel nervous, tense or worried" about 53,0% ie, stressing that the vast majority of respondents elderly caregivers does not present workload and thus their health is not affected frequently.

Nevertheless, it is proposed that there is recovery assistance to the caregiver requiring care actions in their favor, to implement effective interventions aimed at the establishment of formal and emotional supports in order to receive health anxieties and problems of caregivers and, therefore minimize their emotional burden. In this context, it is expected that this study will contribute to the production knowledge, enabling the development of new studies are needed to clarify matters relating to overload and self-reported health problems by caregivers and their implications for the life of the caregiver, for elderly care and health institutions.

REFERENCES

- 1 Mendes M, et al. A Situação social do idoso no Brasil: uma breve consideração. Acta 2005; 18(4):422-6,.
- 2 Fiedler MM, Peres KG. Capacidade funcional e fatores associados em idosos do Sul do Brasil: um estudo de base populacional. Cad. Saúde Pública 2008; 24(2):409-15.
- 3 Brasil. Portaria n 2.528, de outubro de 2006. Política Nacional de Saúde da Pessoa Idosa. Brasília: Ministério da Saúde; 2006.

- 4 Brasil. Publicação do papel do cuidador domiciliar. São Paulo: Instituto de estudos especiais PUC-SP; 1998.
- 5 Brasil. Conselho Nacional de Saúde. Resolução n° 196/96 sobre pesquisa envolvendo seres humanos. Brasília, DF: Ministério da Saúde; 1996.
- 6 Fernandes MGM, Garcia TR. Atributos da tensão do cuidador familiar de idosos dependentes. Rev. Esc. Enferm. USP 2009; 43(4):818-24.
- 7 Nascimento L. et al. Cuidador de Idosos: conhecimento disponível na base de dados lilacs. Rev. Bras. Enferm. 2008; 61(4).
- 8 Mendes G, Miranda S, Borges MM. Saúde do cuidador de Idosos: um desafio para o cuidado. Rev. Enferm. Integrada 2010; 3(1):408-21.
- 9 Gratão ACM. Sobrecarga vivenciada por cuidadores de idosos na comunidade. Tese [Doutorado em Enfermagem] Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2010.
- 10 Schossler T, Crossetti MDG. Cuidador domiciliar do idoso e o cuidado de si: uma análise através da teoria do cuidado humano de Jean Watson. Rev. Texto e Contexto abr./jun. 2008; 17(2).
- 11 Sena RRD, Silva KL, Rates HF, Vivas KL, Queiroz CM, Barreto FO. O Cotidiano do cuidador no domicílio: desafios do bem fazer solitário. Cogitare Enfermagem maio/ago. 2006; 11(2).
- 12 Diogo MJ, Ceolim MF, Cintra FA. Orientações para idosos que cuidam de idosos no domicílio: relato de experiência. Rev Esc Enferm USP 2005; 39(1):97-102.
- 13 Araujo JA, Leitão EMP. O cuidador do paciente em cuidados paliativos: sobrecarga e desafios. Revista Hospital Universitário Pedro Ernesto. 2012;11(2):77-81
- 14 Fonseca FB, Rizzotto MLF. Construção de instrumento para avaliação sócio-funcional em idosos. Texto Contexto Enferm 2008; 17(2):365-73.
- 15 Cassis SVA et al. Correlação entre o estresse do cuidador e as características clínicas do paciente portador de demência. Rev Assoc Med Bras 2007; 53(6):497-501.
- 16 RESENDE, M.C.; DIAS, E.C. Cuidadores de idosos: um novo/velho trabalho. Physis 2008; 18(4):785-800.
- 17 Martins T, Ribeiro JP, Garrett C. Estudo de validação dos questionários de avaliação da sobrecarga para cuidadores informais. Psic. Saúde & Doenças 2003; 4(1):131-148.
- 18 Oliveira, S. et al. Perfil dos cuidadores de idosos atendidos pelo projeto de Assistência interdisciplinar a idosos em nível primário. Ciência, Cuidado & Saúde 2006; 5(2):184-192.
- 19 Brasil. Ministério da Saúde. Guia Prático do Cuidador. 2ed. Brasília: Ministério da Saúde; 2009. 64p.

Received on: 01/08/2015
Required for review: no
Approved on: 01/12/2015
Published on: 30/12/2015

Contact of the corresponding author:
Ilanna Cibele Delgado de Araújo Fonsêca
João Pessoa - PB - Brasil
Email: